LEGISLATURE OF THE STATE OF IDAHO

Sixtieth Legislature First Regular Session - 2009

IN THE SENATE

SENATE BILL NO. 1116

BY HEALTH AND WELFARE COMMITTEE

AN ACT

RELATING TO INSURERS AND ORGANIZATIONS OFFERING HEALTH CARE CONTRACTS; AMENDING SECTIONS 41-1846 AND 41-3915, IDAHO CODE, TO REQUIRE CERTAIN INSURERS AND ORGANIZATIONS TO PROVIDE CERTAIN ORALLY ADMINISTERED MEDICATIONS ON A BASIS NO LESS FAVORABLE THAN CERTAIN INTRAVENOUSLY ADMINISTERED MEDICATIONS; AND DECLARING AN EMERGENCY.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 41-1846, Idaho Code, be, and the same is hereby amended to read as follows:

41-1846. HEALTH CARE POLICIES – APPLICABILITY – REQUIREMENT. (1) An insurer offering a health care policy that does not meet the definition of a managed care plan as provided in section 41-3903(15), Idaho Code:

(a) Must have the intent to render and the capability for rendering or providing coverage for good quality health care services, which will be and are readily available and accessible to its insureds both within and outside the state of Idaho, and such services must be reasonably responsive to the needs of insureds;

(b) When "emergency services" are provided, they shall be provided as set forth in section 41-3903(7), Idaho Code, and shall not require prior authorization;

(c) Shall include on its website and/or send annually to its policyholders:

(i) A statement as to whether the plan includes a limited formulary of medications and a statement that the formulary will be made available to any member on request;

(ii) Notification of any change in benefits; and

(iii) A description of all prior authorization review procedures for health care services;

(d) Shall adopt procedures for a timely review by a licensed physician, peer provider or peer review panel when a claim has been denied as not medically necessary or as experimental. The procedure shall provide for a written statement of the reasons the service was denied and transmittal of that information to the appropriate provider for inclusion in the insured's permanent medical record;

(e) When prior approval for a covered service is required of and obtained by or on behalf of an insured, the approval for the specific procedure shall be final and may not be rescinded after the covered service has been provided except in cases of fraud, misrepresentation, nonpayment of premium, exhaustion of benefits or if the insured for whom the prior approval was granted is not enrolled at the time the covered service was provided; ~~and~~

(f) Shall not offer a provider any incentive that includes a specific payment made, in any type or form, to the provider as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services covered by the health care policy; and

(g) When providing coverage for chemotherapy treatment, shall provide coverage for prescribed orally administered anti-cancer medications used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected anti-cancer medications that are covered as medical benefits.

(2) No health care provider shall require an insured to make additional payments for covered services under a policy subject to subsection (1) of this section, other than specified deductibles, copayments or coinsurance once a provider has agreed in writing to accept the insurer's reimbursement rate to provide a covered service.

SECTION 2. That Section 41-3915, Idaho Code, be, and the same is hereby amended to read as follows:

41-3915. HEALTH CARE CONTRACTS. (1) All health care contracts or other marketing documents describing health care services offered by any managed care organization shall contain:

(a) A complete description of the health care services and other benefits to which the member is entitled;

(b) A description of the accessibility and availability of services, including a list of the providers participating in the managed care plan and of the providers who are accepting new patients, the addresses of primary care physicians and participating hospitals, and the specialty of each physician and category of the other participating providers. The information required by this subsection (1)(b) may be contained in a separate document and incorporated in the contract by reference and shall be amended from time to time as necessary to provide members with the most current information;

(c) Any predetermined and prepaid rate of payment for health care services and for other benefits, if any, and any services or benefits for which the member is obliged to pay, including member responsibility for deductibles, copayments, and coinsurance;

(d) All exclusions and limitations on services or other benefits including all restrictions relating to preexisting conditions;

(e) A statement as to whether the plan includes a limited formulary of medications and a statement that the formulary will be made available to any member on request;

(f) All criteria by which a member may be terminated or denied reenrollment;

(g) Service priorities in case of epidemic, or other emergency conditions affecting demand for health care services;

(h) A statement that members shall not, under any circumstances, be liable, assessable or in any way subject to payment for the debts, liabilities, insolvency, impairment or any other financial obligations of the managed care organization;

(i) Grievance procedures;

(j) Procedures for notifying enrollees of any change in benefits; and

(k) A description of all prior authorization review procedures for health care services.

(2) In addition to the requirements of subsection (1) of this section, an organization offering a general managed care plan shall:

(a) Establish procedures for members to select or change primary care providers;

(b) Establish procedures to notify members of the termination of their primary care provider and the manner in which the managed care organization will assist members in transferring to another participating primary care provider;

(c) Establish referral procedures for specialty care and procedures for after-hours, out-of-network, out-of-area and emergency care;

(d) Allow members direct access to network obstetricians and gynecologists for maternity care, annual visits, and follow-up gynecological care for conditions diagnosed during maternity care or annual visits;

(e) Allow family practice and general practice physicians, general internists, pediatricians, obstetricians, and gynecologists to be included in the general managed care plan's listing of primary care providers; and

(f) When providing coverage for chemotherapy treatment, provide coverage for prescribed orally administered anti-cancer medications used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected anti-cancer medications that are covered as medical benefits.

(3) No managed care organization shall cancel the enrollment of a member or refuse to transfer a member from a group to an individual basis for reasons relating to age, sex, race, religion, occupation, or health status. However, nothing contained herein shall prevent termination of a member who has violated any published policies of the organization, which have been approved by the director.

(4) No managed care organization shall contract with any provider under provisions which require a member to guarantee payment, other than specified copayments, deductibles and coinsurance to such provider in the event of nonpayment by the managed care organization for any services rendered under contract directly or indirectly between the member and the managed care organization.

(5) No health care provider shall require a member to make additional payments for covered services under a health care contract, other than specified deductibles, copayments, or coinsurance once a provider has agreed in writing to accept the managed care organization's reimbursement rate to provide a covered service.

(6) The rates charged by any managed care organization to its members shall not be excessive, inadequate, or unfairly discriminatory. The director may define by rule what constitutes excessive, inadequate or unfairly discriminatory rates and may require a description of the actuarial assumptions and analysis upon which such rates are based as well as whatever other information, available to the managed care organization, he deems necessary to determine that a rate or proposed rate meets the requirements of this subsection. If experience rating is a common health insurance practice in the area served by the managed care organization, it shall have the right to experience-rate its own contracts.

(7) No such contract form or amendment to an approved contract form shall be issued unless it has been filed with the director. The contract form or amendment shall become effective thirty (30) days after such filing unless specifically disapproved by the director. Any such disapproval shall be based on the requirements of section 41-3905, Idaho Code, or subsection (1), (2), (4), (5) or (6) of this section.

(8) The director shall disapprove any contract which, with amendments, does not constitute the entire contractual obligation between the parties involved. No portion of the charter, bylaws, or other constituent document of the managed care organization shall constitute

part of such a contract unless set forth in full therein or incorporated by reference as authorized in this section.

SECTION 3. An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval.